

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-000940

Dr. Powell

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

AMENDED FILED VS JAN 8 1961

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>GREENE</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MISSOURI</b><br>b. COUNTY<br><b>GREENE</b>          |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN<br><b>SPRINGFIELD</b>  |   | c. CITY OR TOWN<br><b>SPRINGFIELD</b>   |  |
| Length of stay in 1b<br><b>40 YRS.</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><b>ST. JOHN'S HOSP.</b>   |   | d. STREET ADDRESS<br>(If outside, give location)<br><b>1520 E. LOMBARD</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>OTIS CALVIN FESPERMAN</b>   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>JAN. 4 1961</b>  |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/6/97</b>                |
| 9. AGE (last birthday)<br><b>63</b>   |   | 10. IF UNDER 1 YEAR IF UNDER 24 HR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>OWNER &amp; OPERATOR</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OTIS SUPER SERVICE</b>  |  |
| 11. BIRTHPLACE (City and state or country)<br><b>STONE, CO. MO.</b>   |   | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>   |  |
| 13a. FATHER'S NAME<br><b>GEORGE M. FESPERMAN</b>  |   | 13b. MOTHER'S MAIDEN NAME<br><b>RUTHIE C. ROWE</b>  |  |
| 14. NAME OF HUSBAND OR WIFE<br><b>URMA G. FESPERMAN</b>   |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>YES W.W. # 1</b>                          |  |
| 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>Address<br><b>MRS. URMA FESPERMAN, SPRINGFIELD, MO</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Pulmonary Emphysema.</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs</b> |
| PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  |   |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |   |   |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.<br>Month, Day, Year   |   |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 20f. CITY, TOWN, OR LOCATION<br>COUNTY STATE  |  |
| 21. I attended the deceased from <b>10-26-45</b> , to <b>1-4-61</b> and last saw him alive on <b>1-4-61</b> .<br>Death occurred at <b>9:15 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.  |   |   |  |
| 22a. SIGNATURE<br>(Degree or title)<br><b>St. P. Madden M.D.</b>  |   | 22b. ADDRESS<br><b>Springfield, Mo</b>  |  |
| 22c. DATE SIGNED<br><b>1-4-61</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE<br><b>1/7/61</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREENLAWN</b>  |  |
| 23d. LOCATION (City, town, or county)<br><b>SPRINGFIELD, MO.</b>  |   | 23e. (State)  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>H.H. LOHMEYER FUNERAL HOME</b>  |   | 25. DATE RECD. BY LOCAL REG.<br><b>1-5-61</b>   |  |
| 26. REGISTRAR'S SIGNATURE<br><b>Effie E. Mecton</b>   |   |   |  |

(Licensed Embalmer's Statement on Reverse Side)

JAN 10 1961

JAN 12 1961

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*DAK Mc Carr*

Licensed Embalmer No.

*2727*

P. O. Address

*Springfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.